STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445218	A. BUILDING _____ B. WING _____	C 08/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTHCARE OF CORDOVA	955 GERMANTOWN PKWY CORDOVA, TN 38018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Intake: TN00028542 A complaint investigation was conducted on 8/24/11 for TN00028542 with actual harm (G level deficiency) being cited at F323. This will be a no opportunity to correct with daily civil monetary penalties being imposed. The facility has been cited a double G, which means during the annual survey completed on 7/7/11 the facility was cited a G level deficiency and during the complaint investigation completed 8/24/11 a G level deficiency was cited.	F 000		
F 323	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on review of the facility's investigation summary, medical record review and interview, it was determined the facility failed to ensure interventions were implemented to prevent accidents for 1 of 4 (Resident #1) sampled residents identified with falls. The failure to implement the interventions to protect Resident #1 resulted in actual harm when Resident #1 sustained a fracture during a transfer. The findings included:	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 323	Continued From page 1 Review of the facility's event summary dated 8/8/11 documented, "[Resident #1's name and room number] Event Date: 8/2/11 at 7:45 PM An investigation was completed regarding above stated incident... [staff] didn't use a mechanical lift to transfer the patient... The two CNAs [Certified Nurse Assistants] attempted to transfer the patient using a "2 man lift" technique that resulted in injury to the patient. The patient was transferred to the hospital and admitted for orthopedic treatment. The patient's daughter has reported that there is a "broken femur"..." A Follow-up Report dated 8/8/11 for Resident #1 documented, "...8/3/11 F/U [follow-up] phone call + [positive] femur fx [fracture]..." Medical record review for Resident #1 documented an admission date of 12/10/08 and a readmission date of 5/4/11 with diagnoses of Peripheral Vascular Disease, Left Below Knee Amputation, Muscle Weakness, Rheumatoid Arthritis, Bipolar Disorder and Osteoarthrosis. Review of a physician telephone order dated 8/2/11 documented, "Send to [hospital name] for evaluation of Rt [right] knee." The lift/transfer assessment form dated 6/8/11 documented, "...TOTAL LIFT REQUIRED yes..." The care plan dated 5/4/11 documented, "...At risk for falls r/t [related to] requires total assist with transfers... Ensure adequate staff and proper equipment for safe transfers... Use hoyer lift for transfers..."A nurses note dated 8/2/11 at 10:42 PM documented, "...resident [#1] sitting on floor upright position but rt [right] leg bent in odd position it was laying sideways... shower chair was next to bed this nurse was told by CNA that resident was being transferred to shower chair	F 323		

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F 323	Continued From page 2 from bed resident's leg caught in shower chair. CNA attempted to reposition leg heard a pop CNAs attempted to assist resident back on to bed resident unable to stand CNAs assisted the resident to the floor..." During an interview in the administrator's office on 8/24/11 at 4:30 PM, the Director of Nursing stated, "...[CNA] got a shower chair, supposedly looked for a lift, said none [no lift available], got co-worker assist to transfer [Resident #1] to shower chair. The resident's leg wrapped around the chair... [CNA] tried to lay her down and heard a pop... " The failure to implement the interventions documented on the lift/transfer assessment and care plan to protect Resident #1 resulted in actual harm when Resident #1 sustained a fracture during a transfer on 8/2/11.	F 323		